Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 9, 2015	2015_256517_0015	008565-15, 006962-15	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village at St.Clair
1800 Talbot Road WINDSOR ON 000 000

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PATRICIA VENTURA (517)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 21 & 22, 2015

Log# 008565-15/CI3046-000102-15; Log#006962-15/CI3046-000097-15/CI3046-000090-15; CI3046-000104-15 and CI3046-000116-15 were completed to determine if the home was in compliance with legislation in regards to responsive behaviours and alleged abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Acting General Manager, Director of Care in training, Acting Director of Care, Assistant Director of Care, one Registered Nurse, three Registered Practical Nurses, five Personal Support Workers, the Exercise Therapist and the Physiotherapist. The inspector reviewed five resident health records, five Critical Incident Reports, the home's policies and protocols for responsive behaviours and abuse/neglect and observed resident to resident and staff to resident interaction throughout the home.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

1) Progress notes for Resident #1 indicated a Dementia Observational System (DOS) where the staff would document observed resident behaviours was initiated on a specified date for Resident #1 after the resident had an altercation with Resident #6 causing injury to resident #6.

Further health record review for Resident #1 revealed there were no DOS describing resident behaviours in the resident health record from the specified date to the date of this inspection.

2) A Critical Incident Report indicated that on a specified date, Resident #4 had an altercation with Resident #3 causing injury to both residents involved. The Critical Incident Report indicated that a DOS was initiated for Resident #4 to monitor resident behaviours.

Further health record review for Resident #4 revealed there were no DOS describing resident behaviours in the resident health record from the specified date to the date of this inspection.

The Director of Nursing in training, Assistant Director of Nursing, Coordinator of a resident home area and General Manager confirmed that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions should be documented and in the resident health record. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

1) Health record review for Resident #3 revealed the Plan of Care for the resident included a specific intervention to be used to reduce the chance of responsive behaviours.

Observations and interviews with two Personal Support Workers revealed the developed intervention was not implemented.

2) Resident health record review for Resident #4 revealed the Plan of Care for the resident included a specific intervention to be used to reduce the chance of responsive behaviours.

Observations and interviews with two Personal Support Workers revealed the developed intervention was not implemented.

3) Health record review for Resident #1 revealed the Plan of Care for the resident directed the staff to monitor Resident #1 when in identified areas at the home to prevent responsive behaviuors.

Further health record review for Resident #1 revealed the resident had three unwitnessed incidents of responsive behaviours with other residents causing injury to the other residents while in these identified areas at the home.

Interview with the Coordinator of a resident home area revealed the expectation was that staff implemented the interventions developed and written in the residents' plan of care for residents demonstrating responsive behaviours. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. When the Licensee had reasonable grounds to suspect that there was abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, the licensee failed to immediately report the suspicion and the information upon which it was based to the Director.

Resident health record reviews revealed:

1. The home submitted a Critical Incident Report to the Director under the category of Abuse/Neglect to report an incident between two residents resulting in harm to one resident three business days after the date of the incident.

2. The home submitted a Critical Incident Report to the Director under the category of Abuse/Neglect to report an incident between two residents resulting in harm to one resident seven days after the date of the incident.

3. The home submitted a Critical Incident Report to the Director under the category of Abuse/Neglect to report an incident between two residents resulting in harm to one resident three days after the date of the incident.

Interview with the General Manager revealed the General Manager was notified of these incidents within eight hours of the time of the incidents. The General Manager also confirmed the expectation was the Director was notified immediately when the licensee had reasonable grounds to suspect that there was abuse of a resident by anyone that resulted in harm or risk of harm to the resident. [s. 24. (1)]

Issued on this 11th day of June, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.